DSS-106A-6
4/98

MENTAL HEALTH SERVICES

CHILD'S NAME: _____ DOB: _____

THERAPIST / COUNSELOR: _____ Phone: _____

PSYCHIATRIST / PHYSICIAN: _____ Phone: _____

COUNSELING / THERAPY SESSION

Date: _____

Current frequency of appointments: Weekly: _____ Twice Monthly: _____ Other: _____

Current Goals (Please list with child's permission.) _____

Please rate the child's progress in meeting all goals on the following scale.

(Has Work To Do) 1 2 3 4 5 6 7 8 9 10 (Work Completed Successfully)

Current Psychiatric Medication (If none, please indicate.): _____

_____

Diagnosis: _____

A conference session with one of the individual(s) circled below is needed. Please call to schedule.

Birth Parent Care Provider Family Services Worker Sibling Psychiatrist Other: _____

Homework Assignment: _____

Notes / Comments: _____

_____

Therapist / Counselor Signature: _____ Next Appointment: _____

MEDICATION MANAGEMENT APPOINTMENT

Date: _____

Height: _____ Weight: _____ Blood Pressure: _____

Psychiatric Medication Prescribed: _____

_____

Diagnosis: _____

Referral for Testing / Evaluation Needed (Please indicate Blood Work, MRI, CT Scan, Other): _____

_____

Physician Signature: _____ Next Appointment: _____

File: Original, Passport Folder
Copy, Professional, Section III.